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Federally Qualified Health Centers: A Time to Adapt, Acclimate, and Secure Funding

With 123 new accountable care organizations (ACOs) announced in 2013[1] and more than 600 public and private ACOs throughout the U.S., ACOs collaborative care networks[2] are emerging throughout the country. With goals to improve quality outcomes, improve the experience of care, and lower costs, the success of these network models depend heavily on an effective primary care foundation. Accordingly, Federally Qualified Health Centers (FQHCs) are pivotally positioned to form or become a key component of these networks.

FQHCs are by and large further along in many of the key areas of healthcare transformation and accountable care. Nearly half are recognized "Patient Centered Medical Homes"—a model of care that is increasingly demonstrating substantial cost savings. Practically all FQHCs are using electronic health records. Further, they are, as a group, far along in managing chronic diseases (the leading drivers of health costs) and reporting data, as they must report health outcomes and financial data regularly to the Health Resources and Services Administration (HRSA).

While the network model opens up opportunities for major reorganization of the healthcare delivery system, there are no guaranteed winners. FQHCs could add significant value and stand to benefit from the financial reward of participating in an ACO or collaborative care network, but they also face significant barriers and risks.

Experts in the healthcare industry recently convened to address these challenges and opportunities at the Primary Care Innovation Circle roundtable discussion, Health Center Investing: FQHCs and Accountable Care. Hosted by Primary Care Development Corporation (PCDC) and co-hosted by CohnReznick LLP and law firm Rivkin Radler, FQHC leaders, executives from major insurance companies, and representatives from community development financial institutions (CDFIs) met to address three key questions:

- Where is the FQHC sector now as it relates to accountable care and ACOs?
- How should FQHCs prepare for ACOs, and what should investors look for?
- What are the risks and opportunities for FQHCs and investors?

Seizing the Opportunity: FQHC Participation in ACOs

With the growth of accountable and collaborative care programs, a number of states are in the process of developing Medicaid ACO and patient-centered collaborative care programs designed to encourage participation from a broad array of provider types, including FQHCs. Tricia McGinnis, Director of Delivery System Reform at the Center for Health Care Strategies, attested that on a national level, states are developing ACO programs that can accommodate and include FQHCs. "States are creating programs that are flexible enough so that FQHCs can participate as the organization, as a part of an organization, or as a network configuration of FQHCs," she explained.

FQHCs are beginning to seize these opportunities. In New York State, three large FQHCs operating in the Hudson Valley—Institute for Family Health, Hudson River HealthCare, and Open Door Family Medical Center—recently joined to form FamilyHealth ACO. The Federally Qualified Health Center Urban Health Network (FUHN), a network of 10 FQHCs in the Minneapolis-St. Paul region launched in 2013, provided lessons for FQHCs in a case study published by the Commonwealth Fund. Among the insights:

- Aligning leadership through the identification of a shared vision;
- Establishing a strong governance structure tasked with overseeing and driving progress;

[1] http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-12-23.html
[2] Defined as a consortium of health care providers with a joint governance structure that provides comprehensive coordinated and integrated health care services in which providers take responsibility for managing the care of a defined patient population.

- Identifying an initial financial investment and commitment;
- Developing a unified strategy for using data to measure progress and identify improvement opportunities; and
- Prioritizing the development of care coordination infrastructure.[3]

The challenges expressed in both of these cases and throughout the discussion focused on demonstrating value and securing investment based on that value. In an accountable care environment, providers are financially responsible for managing the total cost of care of a defined patient population. How can it be proven that the arrangement will result in a decrease in spending? Many providers are not able to accrue the data needed to prove savings before making a substantial investment in building the ACO/provider network and setting up the systems to manage the served population. But how can providers get the investment they need to start the process? Reforming how healthcare is paid for – from volume-based to value-based – should be a key driver, but the pace of progress can hamper efforts at upfront investment.

"Payment reform continues to move forward with certainty, and yet doubts remain with regard to the timeline. We have this contradiction of needing to make the changes now in the absence of having the investment in order to make the new system successful and in hopes of getting investment in the future," said Ronda Kotelchuck, CEO of PCDC.

"At the end of the day, we need an operating margin, and to maintain these margins, we need an investment," stated Peter Epp, Co-Managing Director of CohnReznick's Healthcare Industry Practice.

Investing in the Future: Fueling FQHC Involvement in ACOs and Collaborative Care Networks

FQHCs can reap significant financial rewards through participation in collaborative care networks or ACOs, though many lack the financial resources and infrastructure necessary to participate. While the government will continue to serve as a significant source of FQHC investment, partners such as foundations, private sector investors, and community development financial institutions (CDFIs) will play an increasingly important role in fueling the requisite up-front investment for FQHCs. "In order to grow to 9,000 practice sites by 2020 and serve 35 million people, FQHCs are going to have to find operational capital and investment in the private sector to combine with public investment," said Jim Hunt, President & Chief Executive Officer of the Massachusetts League for Community Health Centers.

Michael Irwin, Managing Director at Citibank, asserted that interest from investment and commercial banks and other lending vehicles does exist, and noted that to have loan options on attractive terms, an FQHC must demonstrate the ability to develop ACO-type arrangements based on new payment models and manage these profitably.

Dan Nissenbaum, Managing Director of Goldman Sachs' Urban Investment Group, explained that while investment in healthcare is in its infancy stages and lacks a clear vision regarding the return on investment, it may be possible to leverage private sector capital to finance public social services in the form of social impact bonds. This financing option may serve as a particularly useful investment tool for FQHCs during this transformation. "The good news is that there are a lot of financing sources out there and structured finance deals with similar issues," Nissenbaum said. "There are investment bankers and CDFIs who do this, and we bring together foundations, government and other motivated folks to create financing vehicles. Ultimately, we look for a strong operating history, strong business model, something we can underwrite against."

Another interested "investor" group is payers themselves. Insurance companies and managed care organizations understand the value of primary care and the role FQHCs can play in reducing overall costs, particularly in populations with chronic illness. Through alternative payment models, third party payers can invest in the infrastructure transformation required to succeed under payment reform and the creation of ACOs. Most of the payers involved in the discussion were active in this line of investing.

However, this is a new landscape, not only for FQHCs, but for those investors. Gaining investment, showing results, and demonstrating the ability to pay back on the investment are left to the healthcare sector to prove the investment.

More Than Up-Front Investment: Changing Payment Models to Address Ongoing Need

The transformation is a monumental task due to the divergent styles between current health center operations and the ACO business model. With payment models evolving from a pay per visit to a pay-for-value and shared savings model, FQHCs need to rethink their traditional fee for service reimbursement methodology. Several of the payers in the room discussed new value-based payment models that they are piloting today to help provide FQHCs with the investment necessary to drive changes while at the same time move the payment model toward paying for outcomes.

The payment models have three common characterisitics:

1. The payment of a fixed amount per member per month (PMPM) as investment in the infrastructure requirements to transform the payment model. Often this fixed payment PMPM would cover care management services and/or other costs necessary to accomplish a patient-centered care environment;
2. An incentive payment for the attainment of certain performance metrics and/or health outcomes; and
3. A surplus-sharing arrangement whereby the FQHC can share in any savings created by the implementation of the pilot project.

These new payment models allow FQHCs to access a certain amount of infrastructure investment while at the same time participate in an emerging value-based payment model. However, this payment methodology does not address the initial upfront financial investment FQHCs would require for participating in full-risk payment models.

Conclusion

FQHCs stand to benefit from the financial rewards of participating in an ACO or collaborative care network, but they face significant financial barriers associated with amassing the financial reserves required to take on risk as well as building and maintaining the infrastructure necessary to participate. A successful future for health centers in the accountable care environment begins with a strategy that seeks to leverage the benefits that FQHCs bring to the market. Educating the investment community, as well as third party payers, about the value of FQHCs in improving health and lowering the total cost of care will support the critical start-up investment needed for FQHCs to succeed in this new and expanding environment.

[3] http://www.commonwealthfund.org/~/media/Files/Publications/Case%20Study/2013/Oct/1710_Schoenherr_FQHC_case%20study_v2.pdf

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About Primary Care Development Corporation (PCDC)

The Primary Care Development Corporation (PCDC) is a nationally recognized nonprofit whose mission is to expand access to primary care in underserved communities. PCDC currently achieves this mission through three programs: capital financing to build and expand primary care infrastructure; technical assistance to help primary care practices improve their performance and operate more efficiently; and public advocacy to support policies that sustain and expand primary care. PCDC began in 1993 in New York, and now operates nationally, providing capital financing and technical assistance in states and communities throughout the US, and playing an increasingly important role in shaping national policy related to primary care.